RUN DATE:	11/21/2005			RS CHECKWRITE SUMMARY REPORT				1
				CHECKWRITE DATE: 11/23/2005	+	1	+	+
				FINANCIAL PAYER: NCDMH	+		<del>                                     </del>	+
					1		TOTAL	TOTAL
		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404901	CMORA MOUNTS TAIM	0	0	*** NO DATA TO REPORT ***				
3101301	SMOKY MOUNTAINM H/DD/SAS			10 2111 10 112011				
	11/00/383							
		0	0		(	0	0	0
3404904	III AMARINI II AUGUS AN	21	2132	DUPLICATE OF CLAIM-SYSTEM				
	WESTERN HIGHLAN DS LME							+
		191	42	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME		2204	8674	6470
				n PAILENI NAME				+
								+
		79	13	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN	1			↓
3404910	DAMINIA NO	8535	259	SERVICE FACILITY LOCATION WAS	1		-	+
	PATHWAYS			NOT INCLUDED IN YOUR 837.	+	-	+	+
				PLEASE RESUBMIT YOUR CLAIM WIT	1			+
								$\perp$
		11	72	CLIENT NOT ELIGIBLE ON SERVICE	(	547	13701	13154
				DATE	1		<b></b>	-
					+		<del>                                     </del>	+
		8534	63	SERVICE FACILITY LOCATION IS N				
				OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				
3404912	CATAWBA COUNTYM	11	65	CLIENT NOT ELIGIBLE ON SERVICE DATE				
	ENTAL HEALT			DATE				+
								+
		79	20	THIS SERVICE IS NOT PAYABLE TO	10	121	694	573
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		8599	12	DETAIL NOT COVERED BY COMBINAT				
		0000		ION OF RECIPIENT, PROVIDER AND				+
				BENEFIT PACKAGE.				
3404913	MECKLENBURG COM	8933	106	ADTNC INELIGIBLE TO RECEIVE SE				
	ENTAL HEALT			RVICES IN IPRS.				
		8599	49	DETAIL NOT COVERED BY COMBINAT	125	242	1080	838
				ION OF RECIPIENT, PROVIDER AND		2.12	1000	030
				BENEFIT PACKAGE.				
		10			1			↓
		10	37	DIAGNOSIS OR SERVICE INVALID F OR CLIENT AGE. VERIFY CID,	+		<del>                                     </del>	+
				DIAGNOSIS, PROCEDURE CODE FOR	+	-	+	+
					1		<del> </del>	+
3404916	CROSSROADS BEHA	0	0	*** NO DATA TO REPORT ***				$\perp$
	VIORAL HEAL	-						
					1			
		0	0		<del> </del>	-	-	+ -
		1				0	0	0
					1			+
3404917	CENTERPOINT HUM	11	238	CLIENT NOT ELIGIBLE ON SERVICE				$\perp$
	AN SERVICES			DATE				<u> </u>
					1		<b></b>	-
		8599	233	DETAIL NOT COVERED BY COMBINAT	+ .	772	3314	2542
				ION OF RECIPIENT, PROVIDER AND	3	772	3314	2542
		1		BENEFIT PACKAGE.	1			<b>†</b>
<del></del>								
_		10	123	DIAGNOSIS OR SERVICE INVALID F	1			
				OR CLIENT AGE. VERIFY CID,	1		<b></b>	-
				DIAGNOSIS, PROCEDURE CODE FOR	+	1	+	+
3404918	ROCKINGHAM CO M	0	0	*** NO DATA TO REPORT ***	+	1	<del>                                     </del>	+
	ENTAL HEALT				1		<u> </u>	1
		0	0		(	0	0	0
		1	1		1	l .	1	1

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404919	OUTE BODD OF HEN	8599	215	DETAIL NOT COVERED BY COMBINAT				
3101313	GUILFORD CO MEN TAL HEALTHC	0333	213	ION OF RECIPIENT, PROVIDER AND				
	TAB HEADING			BENEFIT PACKAGE.				
		8931	39	AMTNC INELIGIBLE TO RECEIVE SE	47	365	13350	12985
				RVICES IN IPRS.				
		8536	21	ATTENDING PROVIDER TYPE AND SP				
		0330	21	ECIALTY COMBINATION IS NOT				
				VALID FOR SUBMITTED BILLING PR				
3404920	ALAMANCE CASWEL	8599	2622	DETAIL NOT COVERED BY COMBINAT				
	L AREA MH D			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8534	468	SERVICE FACILITY LOCATION IS N	5	3456	5499	2043
				OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F				
				PROVIDER. PLEASE VERIFI INE F				
		11	148	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
3404921	ORANGE PERSON C	5312	2761	PRIOR AUTHORIZED DOLLARS EXCEE				
	HATHAM AREA			DED				
		8505	196	CLAIM DENIED DUE TO INSUFFICIE				
		0303	196	NT BUDGET	6	3284	8173	4889
		8599	120	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404922	THE DURHAM CENT	8329	67	CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS				
	ER			R CANNOT BE THE SAME AS THE LMA				
				Ins and				
		11	7	CLIENT NOT ELIGIBLE ON SERVICE	0	74	74	
				DATE				
3404923	FIVE COUNTY MH	8622	76	60 RESIDENTIAL LEVEL II TREATM				
				ENT RECEIVED, PA IS REQUIRED				
				FOR ADDITIONAL SERVICE.				
		8599	29	DETAIL NOT COVERED BY COMBINAT	_			
		0333	2.5	ION OF RECIPIENT, PROVIDER AND	3	175	2741	2566
				BENEFIT PACKAGE.				
		79	26	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
24040		0524	246	ADDITION TO AN AREA TO A CONTROL OF THE CONTROL OF				
3404925	SANDHILLS CENTE	8534	346	SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING				
	R FOR MH/DD		-	PROVIDER. PLEASE VERIFY THE F		<del> </del>		
	+	+	+			<del>                                     </del>		
	+	8599	127	DETAIL NOT COVERED BY COMBINAT	95	1138	11073	9935
				ION OF RECIPIENT, PROVIDER AND	33	1130	11073	,,,,,
				BENEFIT PACKAGE.				
_		11	108	CLIENT NOT ELIGIBLE ON SERVICE				
-				DATE				
3404926	001100103-05	21	2894	DUPLICATE OF CLAIM-SYSTEM		<del>                                     </del>		
J101320	SOUTHEASTERN RE		2034	DOLLIONE OF CHAIR-SISIES		<del> </del>		
	G MENTAL HL							
	+	-	_			<del>                                     </del>		
		8599	486	DETAIL NOT COVERED BY COMBINAT	450	5248	7533	2285
			+	ION OF RECIPIENT, PROVIDER AND	430	3240	/333	220
				BENEFIT PACKAGE.				
		8518	450	CLAIM DENIED, SUBMITTED BEYOND				
				FILING TIMELIMIT. PRIOR			-	
				FISCAL YEAR DOS (JULY 1 - JUNE				
				1	1			

			1	1	ı			momax
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
	FROVIDER NAME				DENTALS	DENTALO	FINALIZED	FAID
3404927	CUMBERLAND CO M	8599	57	DETAIL NOT COVERED BY COMBINAT				
	HC			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8621	48	60 RESIDENTIAL LEVEL III TREAT	0	125	8088	7963
				MENT RECEIVED, PA IS REQUIRED				
				FOR ADDITIONAL SERVICE.				
		10	15	DIAGNOSIS OR SERVICE INVALID F				
				OR CLIENT AGE. VERIFY CID,				
				DIAGNOSIS, PROCEDURE CODE FOR				
3404929	LEE HARNETT MH/	0	0	*** NO DATA TO REPORT ***				
	DD/SAS							
		0	0		0	0	0	0
3404930	JOHNSTON COUNTY	8931	44	AMTNC INELIGIBLE TO RECEIVE SE				
	MNTL HLTHC			RVICES IN IPRS.				
	+	8599	17	DETAIL NOT COURDED BY COMPANIE	1	1	<del>                                     </del>	
	+	0333	± /	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	64	106	4159	4053
	+		1	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	1	1	<del>                                     </del>	
	+	1		DENDITI FACINGE.	1	-	<del>                                     </del>	
	+	8935	14	ASTNC INELIGIBLE TO RECEIVE SE	<del>                                     </del>	<del>                                     </del>	<del> </del>	
	+	0333	- 4	RVICES IN IPRS.	<del>                                     </del>	<del>                                     </del>	<del> </del>	
	+			IVIOLO IN IERO.	<del>                                     </del>	<del>                                     </del>	<del> </del>	
	+	1			1	-	<del>                                     </del>	
3404931	MAKE CO RIM COO	8599	288	DETAIL NOT COVERED BY COMBINAT	<del>                                     </del>	<del>                                     </del>	<del>                                     </del>	
3101331	WAKE CO HUM SVC	0000	200	ION OF RECIPIENT, PROVIDER AND				
	BILLING OF			BENEFIT PACKAGE.				
	+							
	+	8931	119	AMTNC INELIGIBLE TO RECEIVE SE	199	773	5425	4652
	-			RVICES IN IPRS.	133	773	3423	4032
	-							
	-	8935	70	ASTNC INELIGIBLE TO RECEIVE SE				
	-			RVICES IN IPRS.				
3404932	RANDOLPH/SANDHI	0	0	*** NO DATA TO REPORT ***				
	LLS CO MH C							
		0	0		0	0	0	0
3404933	SOUTHEASTERN CT	8599	302	DETAIL NOT COVERED BY COMBINAT				
	R FOR MH/DD			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		11	144	CLIENT NOT ELIGIBLE ON SERVICE	15	715	2303	1588
				DATE				
						1		
		5404	80	SEVERE DUPLICATE: SAME ATTO PR				
				OV/PCODE/TOS/DOS/MOD			<b></b>	1
	+		1		1	1	<del>                                     </del>	
3404934		8535	1075	SERVICE FACILITY LOCATION WAS	1	1	<del>                                     </del>	
J107334	ONSLOW CARTERET	0333	2073	NOT INCLUDED IN YOUR 837.	<del> </del>	<del>                                     </del>	<del> </del>	
	BEHAV HEAL		-	PLEASE RESUBMIT YOUR CLAIM WIT	<del> </del>	<del>                                     </del>	<del> </del>	
	+		1					
	+	8599	229	DETAIL NOT COVERED BY COMBINAT	48	1828	3007	1179
	+		1	ION OF RECIPIENT, PROVIDER AND	48	1828	3007	11/9
	+			BENEFIT PACKAGE.	<b> </b>	<b> </b>	<del>                                     </del>	
	+		1		<del>                                     </del>	<del>                                     </del>	<del>                                     </del>	
	+	8534	124	SERVICE FACILITY LOCATION IS N	<del> </del>	<b>+</b>	<del>                                     </del>	
	+	1		OT A VALID IPRS ATTENDING	<b> </b>	<b> </b>	<del>                                     </del>	
	+			PROVIDER. PLEASE VERIFY THE F	<b> </b>	<b> </b>	<del>                                     </del>	
	+		1		<b> </b>	<b> </b>	<del> </del>	
3404935	WAYNE CO MENTAL	0	0	*** NO DATA TO REPORT ***				
	HEALTH CTR		1		<b> </b>	<b> </b>	<del> </del>	
	1		1		1		1	
	+							
		0	0		0	0	0	0
			1					
	_							
3404936	WILSON-GREENE M	8518	3	CLAIM DENIED, SUBMITTED BEYOND				
3404936	WILSON-GREENE M ENTAL HEALT		3	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR				
3404936	WILSON-GREENE M ENTAL HEALT		3					
3404936			3	FILING TIMELIMIT. PRIOR				
3404936			3	FILING TIMELIMIT. PRIOR	0	4	100	96
3404936		8518	3	FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	0	4	100	96
3404936		8518	3	FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	0	4	100	96

		1		T				momax
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404937	EDGECOMBE NASH	21	1	DUPLICATE OF CLAIM-SYSTEM				
	MNTL HLTH C							
		0	0		0	1	1	
							_	
3404938	VGFW DBA RIVERS	0	0	*** NO DATA TO REPORT ***				
	TONE COUNSE							
		0	0		0	0	0	
					Ü	Ü		
3404939	NEUSE MENTAL HE	11	93	CLIENT NOT ELIGIBLE ON SERVICE				
	ALTH CENTER			DATE				
		8599	10	DETAIL NOT COVERED BY COMBINAT		112	931	819
				ION OF RECIPIENT, PROVIDER AND		112	331	013
				BENEFIT PACKAGE.				
		79	4	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN	1	1		
	1			THOUSEN THE AND SPECIALITIES		-		
3404941	PITT CO MH/DD/S	0	0	*** NO DATA TO REPORT ***	1	1		
	AS CENTER							
		0	0		0	0	0	C
3404942	ROANOKE CHOWANH	21	23	DUPLICATE OF CLAIM-SYSTEM				
	UMAN SERVIC							
		11	12	CLIENT NOT ELIGIBLE ON SERVICE	8	46	162	116
				DATE				
		8931	6	AMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				
3404943	ALBEMARLE MENTA	79	54	THIS SERVICE IS NOT PAYABLE TO				
	L HEALTH CE			YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
				PROVIDER TIPE AND SPECIALIT IN				
		8931	29	AMTNC INELIGIBLE TO RECEIVE SE	44	139	936	797
				RVICES IN IPRS.		133	330	131
		537	12	PROCEDURE IS NOT COVERED FOR T				
		1	1	HIS DATE OF SERVICE	1	1		
					1	<del>                                     </del>		
3404944	EASTPOINTE HUMA	8518	10	CLAIM DENIED, SUBMITTED BEYOND	1	1		
	N SERVICES			FILING TIMELIMIT. PRIOR		1		
				FISCAL YEAR DOS (JULY 1 - JUNE				
		11	2	CLIENT NOT ELIGIBLE ON SERVICE	0	12	12	C
			-	DATE	-	<del> </del>		
					<del> </del>	<del>                                     </del>		
3404946	FOOTHILLS AREAM	0	0	*** NO DATA TO REPORT ***				
	ENTAL HEALT					l		
		0	0					
		U	U		0	0	236	236
			-		-	<del> </del>		
3404957	TIDELAND MENTAL	8599	335	DETAIL NOT COVERED BY COMBINAT	<del> </del>	<b>-</b>		
	HEALTH CTR		1	ION OF RECIPIENT, PROVIDER AND	l .	1		
				BENEFIT PACKAGE.		1		
		11	35	CLIENT NOT ELIGIBLE ON SERVICE	8	413	2769	2356
				DATE	1			
	1		1		1	1		
								1
		8518	26	CLAIM DENIED, SUBMITTED BEYOND				
		8518	26	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR				
		8518	26					

## Sheet1

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404979	NEW RIVER AREAM	21	182	DUPLICATE OF CLAIM-SYSTEM				
	H/DD/SA PRO							
		8599	63	DETAIL NOT COVERED BY COMBINAT	51	332	3405	3073
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8931	46	AMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				